From the Assistant Secretary's Desk — MSHA meets December 31st deadline on Corrective Action Plan: Upper Big Branch Mine-South Internal Review

From the Desk of the Assistant Secretary

Immediately following the April 5, 2010 disaster at the Massey Energy's West Virginia Upper Big Branch mine, which claimed the lives of 29 miners and injured two others, I directed that a full and thorough internal review be conducted to examine MSHA's actions prior to the event. Consistent with agency policy, the review was to identify any shortcomings in MSHA's performance so that the agency could take actions to address them and improve safety and health. The review that followed was one of the most comprehensive internal reviews conducted in MSHA history, and it resulted in the most extensive changes at MSHA in decades, improving mine safety and health for the nation's miners and changing how we do business at the agency.

However, MSHA did not wait for the internal review to publish its findings and recommendations before putting into place a number of administrative, organizational and regulatory reforms to respond to the tragedy. Some reforms were in progress before the tragedy occurred and many began immediately following the tragedy.

They included the implementation of enhanced enforcement programs, such as impact inspections and a revised Pattern of Violations (POV) process, and the publication of a number of program bulletins to the industry concerning ventilation, the prohibition against advance notice, hazardous condition complaints and the right to request inspections, miners' rights and the accumulation of combustible materials and rock dust.

MSHA also split Coal District 4 into two districts, and upgraded the Mt. Hope Laboratory. In addition, MSHA reorganized the Office of Assessments to better support MSHA's special enforcement programs, such as impact inspections, POV and scofflaws; investigation programs including miners' rights and 110 Mine Act investigations; and the enforcement auditing program.

The agency also engaged in targeted rulemaking, publishing an emergency temporary standard on the "Maintenance of Incombustible Content of Rock Dust," which became a final rule; a final examination rule that requires operators of underground coal mines to conduct more thorough examinations to find and fix commonly cited hazardous conditions; and a final POV rule aligning it with the original intent of Congress to rein in chronic violations. Under the new POV rule, the monitoring MSHA did under the PPOV process is now the responsibility of operators, inspecting and monitoring compliance at their own mines and taking corrective actions before a mine meets the POV screening criteria.

The internal review report delivered on March 6, 2012 contained 100 recommendations, and I personally committed that the agency would address these recommendations for reform within specific timetables. Meeting the aggressive deadlines was a major challenge for MSHA because of other demands facing the agency, such as mission needs and other obstacles we faced due to sequestration and the government shutdown. Nonetheless, MSHA was able to maintain its schedule throughout the process and finish all of the corrective actions on time. We could not have done this without the hard work and dedication of the employees at the agency.

These corrective actions included the revision or development of over 40 policy directives, including the significant revision of the Coal and Metal/Nonmetal Mine Inspection Procedures handbooks and the development of a new Roof Control Handbook; more than twenty separate training sessions for MSHA personnel on issues raised by the internal review; several technology changes, such as a modification of the Mine Plan Approval (MPA) database system to track operator responses to MSHA's requests for plan revisions, improvements to the Inspectors' Portable Application for Laptops (IPAL) for inspectors and the integration of a common tracking system to track all retraining received by inspectors; and revisions to the Coal Mine Health Inspection Procedures Handbook and MSHA Program Policy Manual clarifying the process for assigning new mechanized mining unit (MMU) numbers and their respirable dust standards, collecting bimonthly respirable dust samples for MMUs and establishing criteria for the time frames for abating violations of respirable dust concentration standards.

MSHA also developed and implemented a centralized directive system to provide better oversight over all the agency's directives and policy guidance and to ensure their consistency. In addition, MSHA worked with the Holmes Mine Safety Association, state agencies and the mining community to address a number of gaps in mine rescue, which also led to improved mine rescue coordination and the creation of the national Holmes Mine Rescue Association within Holmes to support mine rescue and provide guidance on mine rescue into the future.

MSHA continues to assess and implement other actions, such as rulemaking on issues related to the Upper Big Branch disaster, which have been announced in MSHA's most recent regulatory agenda.

As noted, those and other actions taken by MSHA and the mining community have resulted in a number of mine safety improvements. MSHA's enhanced enforcement efforts, such as the POV process, have resulted in substantially fewer mines with chronic violation records. MSHA has also stepped up its advocacy on behalf of miners who have been retaliated against for making safety complaints and has filed a record number of temporary reinstatement and discrimination cases on their behalf. Respirable dust levels have been reduced to the lowest exposure levels in history. Those and other actions taken by MSHA and the mining community have resulted in the lowest fatal and injury rates in 2011 and again in 2012, and the lowest fatal and injury rates and the number of mining deaths ever recorded in a fiscal year in FY2013. Over that same period, mine operator compliance continuously improved.

Each quarter beginning in June 2012, MSHA has posted the corrective actions on its website to keep the mining community, interested parties and the public informed about the actions we were taking and our progress in meeting the timelines for completing them. You can see the latest---and the last---quarterly posting, ending December 31, 2013, along with the previous postings on the Upper Big Branch single source page at: http://www.msha.gov/PerformanceCoal/UBBInternalReview/UBBCorrectiveActions.asp.

As I have said on a number of occasions, the tragedy at UBB unquestionably shook the very foundation of mine safety and caused us all to take a deeper look at the weaknesses in the safety net expected to

protect the nation's miners. It caused us to re-double our efforts to instill a culture of prevention in mining. There has been an intense examination of that accident, and MSHA has undergone significant change as we have sought to find and fix deficiencies in mine safety and health. Our corrective actions and other initiatives are part of MSHA's ongoing efforts to implement and enforce the nation's mine safety laws and to improve health and safety conditions in the nation's mines so miners in this country can go to work, do their jobs, and return home to their families safe and healthy at the end of every shift.

Additional Information

- Corrective Action Plan: Upper Big Branch Mine-South Internal Review (As of 12/31/2013)
- Assistant Secretary Corrective Actions (As of 12/31/2013)